NORTH CAROLINA MENTAL HEALTH PLANNING AND ADVISORY COUNCIL

Adult Committee Meeting
July 13, 2007 10am-1:00pm
Summary of Meeting Notes

Present at the Adult Committee Meeting were: Jeff McLoud, Laura White, Emily Moore, Stan Oathout, Mary Edwards, Dan Fox, Vendia Currie, Densie Lucas, Dorothy Best, Kaye Holder, Nidu Menon (from the Quality Management Team), and Lisa Jackson. Joining by phone were Loretta King, Katie Sawyer, and Beverly Varner.

Jeff McLoud welcomed members and guests and everyone did an introduction.

Tracking and Reporting Data:
Lisa discussed the timeframes for completion of the Block Grant Plan and Implementation Report and also explained the difference between National Outcome Indicators (NOMs) and state indicators used in the Block Grant Plan and Report. There will be three additional NOMs tracked this next fiscal year in North Carolina: retention of employment, social connectedness, and improvement in level of functioning.

Nidu discussed the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) and the North Carolina Consumer Satisfaction Survey (which is given in October).

NC-TOPPS is the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) measures outcome and performance for Substance Abuse and Mental Health consumers. NC-TOPPS captures key information on a consumer's current episode of treatment. The NC-TOPPS Advisory Committee (composed of members who represent the diversity of treatment programs, populations, regions, and consumers) and reflects the four regions of the state.

In May, the Adult Committee reviewed justice-specific questions in the adult section of NC-TOPPS and made recommendations to make some of the questions more consumer-friendly. Committee members approved the document containing their comments and input today as written. These recommendations will be reviewed by the Advisory Committee and may be incorporated into NC-TOPPS as soon as June, 2008. Information in NC-TOPPS will soon be accessible at the provider level by providers. NC-TOPPS is a personal interview between the consumer and provider and is given initially at the first visit and then periodically after that. Providers see the value in taking the time (30-40 minutes) to complete the NC-TOPPS assessments when they see and understand the data outcomes. Committee members asked if there were too many questions; there are about 60 questions all together.

Nidu discussed having *Providers' Report Cards* which would serve as an incentive for providers to achieve higher ratings, etc. The Report Cards have been in development for about 6 months and should be available by the end of the year. Groups working on this project include members of the State CFAC (Consumer and Family Advisory Committee), Quality Management Team staff, and representatives from the NC Council of Community Programs. Peer Support Specialists are another resource who can help providers understand consumers better. Cultural sensitivity issues are evident here too; providers need to be sensitive to the different cultural needs of their consumers.

If consumers remain in services, a longitudinal analysis could be done which would help demonstrate whether services have impacted the consumer's outcomes over time. Part of the treatment process that is so beneficial to consumers is being able to demonstrate how far they have come. One committee member indicated that a family member had been given the survey by phone and the interviewer did not use language that the relative could understand; input by committee members was that the language needs to be more consumer-friendly and most certainly done face to face.

The North Carolina Consumer Satisfaction Survey (CSS) may eventually be web-based. One question came up about whether the surveys completed in a positive or negative manner could be replicated multiple times if the survey goes web-based? Two of the three new NOMs mentioned above will have measurable data through the responses to the CSS: the NOM for social connectedness and the NOM for improvement in functioning level. Lisa read the questions from the CSS that will be used to gauge how consumers rate their social connectedness and functioning level. Approximately 12,000 consumers/family members respond to the survey each year.

Nidu discussed individual indicator tables, such as the table regarding readmission rates for 30 days and 180 days which tracks those people readmitted within 30 or 180 days from the State hospitals.

NC-TOPPS will be utilized to track a new NOM for employment; Nidu explained how different categories of employment would be assessed, such as the number of people who are employed, how many are employed full time, part-time, or unemployed, but seeking work.

Committee input regarding achievements/accomplishment, challenges/needs, and priorities:

- Training: Council members are involved in training, such as recovery training with Psychosocial Rehabilitation Programs, Wellness Recovery Action Plan (WRAP) training, Peer Support Specialist training, working with CFACs, and Family to Family training through NAMI (National Alliance on Mental Illness). In fact, NAMI's Family to Family training has expanded in number of attendees and in number of locations. LMEs are sending staff to trainings as well, such as WRAP training, Family to Family training and the Crisis Intervention Training (CIT). North Carolina Mental Health Consumer Organization has trained more

WRAP facilitators and collaborates with other advocacy organizations in doing training. There have been 2 peer to peer specialists who have formed additional support groups; they had interest in going through the training and then went on to lead other support groups.

- Progress has been made in community capacity; if Community Support is done correctly, it does provide a unique support; Community Support Specialists have filled a gap in the service delivery system.

- Assertive Community Treatment Teams have been around a long time, but now we have an ACTT model with fidelity.

- Many LMEs have provider meetings on a monthly basis.

- Peer Support Specialists can help consumers in the process of systems navigation and can link them with community resources.

- Despite North Carolina being a state in transition, there are growing "pockets of excellence" in specific locales.

- The Division of MH/DD/SAS and the legislature have put benchmarks in place to track Evidence-Based Practices and funding expenditures.

- The recent passage of the mental health Parity legislation by the Senate and House; this bill requires health insurers in the state to provide the same level of coverage for treatment of severe depression, schizophrenia or other mental illnesses as they do for physical illnesses.

- Local newspapers in many areas are now showing how the legislators voted; they are increasingly looking to consumers for input; articles are being written about local service providers to inform and educate the public.

- All LMEs have crisis plans.

- Effective 2/07 the Interagency Memorandum of Agreement (IMOA) was signed and went into effect between the Division of Vocational Rehabilitation Services and the Division of Mental Health/Developmental Disabilities/Substance Abuse Services; this IMOA focuses on employment goals (some mutual goals between the two divisions and other individual divisional goals); some components include discharge planning from state psychiatric hospitals and training.

- One Council member has introduced WRAP training in adult day care settings in Wake County; she worked with older adults who had unmet needs and were dealing with loneliness and isolation.

♦There is limited state funding for trainings; some trainings need statewide centralized integration, such as for the expansion of Crisis Intervention Teams. Law enforcement officers need incentives to persuade chiefs to "buy in" to such programs. Increased funding is needed for Crisis Intervention Team training; if this training is "watered down," there is the likelihood of losing fidelity to the model.

♦Consumer education is critical to reduce stigma. There is also a need for providers to have training/education about other local providers and what services they provide.

♦LMEs need objectives that match the State Strategic Plan; LME accountability is tied to the contents of their local business plan.

♦Gang activity is increasing in some parts of the state and this is another area that needs more attention by law enforcement.

♦As a result of paid claim reviews, it seems that some providers need to better understand the services being provided—how the services should look when delivered correctly.

♦Community capacity should be developed in other areas besides increasing local crisis services, such as expanding jail diversion programs or having step-down type services for people to go to when they leave Assertive Community Treatment Teams (ACTT).

♦Training is needed for Peer Support Specialists and getting the proper education about their role is critical. The certification training for Peer Support Specialists is intense in North Carolina; other co-workers need to know what skills and abilities the Peer Support Specialist can bring to the team. We need to build in a recovery component for the Peer Support Specialist. They need on-going weekly support groups.

♦There should be more collaborative relationship-building between agencies and programs.

♦Uniformity should exist in consumer education/training and there should be incentives for people to realize the value/benefit of the training.

♦We need to look at ex-offenders who take on the role of Peer Support Specialists.

♦Some providers are having problems with cash flow.

♦Confusion exists over which services can be provided concurrently (e.g., PSR and ACTT cannot be done together); if someone has the intensive need level for ACTT services, they would typically not be appropriate for PSR until level of need reaches that of the consumer being ready to "step down" to a less intensive service, such as PSR.

♦Improvement needs to be made in service delivery for older adult consumers with mental illness.

♦Disparity exists in funding across the three disability groups; substance abuse admissions are up in state psychiatric hospitals when these admissions should be going to Alcohol and Drug Abuse Treatment Centers (ADATCs).

Adult Committee Priorities for SFY 2007-08:

»Education/Training
-Consumer and Family education: Adult Committee members feel that consumer and family education is critical, especially in terms of self advocacy, consumer rights and advocacy education in general. Family education should be across both child and adult lines. There should be on-going support for consumers in positions of Peer Support Specialists (e.g., ACT Teams) and as consumer employees in the mental health field.

-Provider/Direct Care/Support Staff: Providers and direct/support staff need education/training that emphasizes recovery-based principles, values and practices. Better trained staff who receive appropriate support and supervision should have higher retention rates.

»Evidence-Based Practices (EBPs)
-Adult Committee members support the continued growth and development of EBPs (which were created using recovery principles), particularly any EBPs that focus on:

--jail diversion practices/programs, such as Crisis Intervention Teams (with the goal of statewide implementation)
--after care practices/programs on a post incarceration basis (we need more support systems/re-entry programs in place to help those returning from incarceration)
--services for older adults with mental illness (mental illness is often not recognized in older adults and is undiagnosed or under-treated)
--practices/services that support Peer Support Specialists or consumer employees (consumers need on-going support to be more effective in their positions)

»**Housing**
-Adult Committee members feel strongly that there should be a variety of safe, affordable housing options for people with mental illness; having stable housing allows consumers to focus on other aspects of their recovery (such as employment, budgeting and finance, socialization, medication management, and other components of daily living).

»**Recovery**
-There must be systematic support for the concept of recovery across the whole service delivery system. Recovery is interwoven throughout the public system, whether in the trainings or educational initiatives or as the foundation for Evidence Based Practices.

Wrap-Up:
Mileage reimbursement forms were completed; Jeff thanked everyone for their participation and adjourned the meeting. Full Council will meet on Friday, August 3, 2007 at 10:00am.